For the sake of doing something, I ordered an ointment, containing 100 grains of iodide of potassium and 10 grains of iodine to an ounce of lard, to be rubbed into the tumour twice a day: he was also to take a grain of the iodide twice daily. I confess I did not expect much, but the result astonished me.

After treatment of this kind for about three weeks, he complained that the rubbing hurt him; and on examining the arm, I plainly detected *crepitus*, and found the tumour, like an iceberg in summer, rapidly breaking up in every direction. The tale is told. I persevered more carefully with unusual interest, and in the end re-absorbed almost all the callus, left the fragments moveable, and thus "*refractured the bone by ointment.*" All medicine was then stopped, and the bone properly set in splints. He made a capital recovery, callus being again thrown out; and the fragments re-united in their proper places.

Have any of my brethren met a case in which the absorbent power of iodine has been so powerfully shown? I never had much faith in the disfiguration of a lady's neck by daubing iodine paint over it; nor can I say that many buboes, scrofulous glands, or enlarged livers have retreated before my brush; but for the future I will put more faith in the steady introduction of iodine into the system when I want absorption.

This treatment might be successful in partially removing one deformity, for which a surgeon is often unjustly blamed. It is one of the most difficult things I know of to keep a child quiet when the apparatus for a fractured clavicle has been applied. Consequently, an unsightly lump on the bone results, especially if the little patient be a girl, who must always have her biggest doll in bed with her. When the girl grows into the young lady, and wishes to wear low dresses in a ball room, the surgeon is blamed for the deformity which the childish restlessness caused. Without going to the length of refracturing, which would then be hardly possible—if advisable, the tumour might be sensibly reduced.

I am quite aware of the refracture of bones from blood diseases, but then we do not want it; when we do, it is more rare to be able to procure it.

November, 1867.

DISLOCATION BACKWARDS OF THE STERNAL END OF THE CLAVICLE.

BY ASST. SURGEON J. A. PURREFOY COLLES, M.D., L.R.C.S.I.,
Officiating Professor of Physiology in the Medical College of Bengal.

KHUDA-I-DOST KHAN, aged 40, a Ghilzai Pathán, of the Azárkhail tribe, was admitted into the 1st Surgeon's ward of the Medical College Hospital (of which I was temporarily in charge) on the night of the 13th-14th November, 1867. He is an itinerant "bazzáz" (cloth merchant), and has but recently come to Calcutta. On the night of the 13th he was getting out of the way of a buggy which was bearing down upon him, when another buggy, coming up behind him, struck him on the back of the left shoulder, and rolled him over. He became insensible, but thinks that the buggy wheel passed over the front of the left shoulder, and thence across the chest; but his only reason for this belief is the fact that his left clavicle and some of his right ribs have suffered. He was picked up by the Police and brought to the Medical College Hospital.

Present state, 14*th November*.—A rather haggard man, with grizzled hair, looking older than his reputed age, and even dirtier than his countrymen usually are, both which conditions depend, probably, on the fact that his wordly affairs have not prospered lately. He has a superficial lacerated wound, or rather a deep excoriation, on each knuckle of the right hand, and another over the right malar bone; all evidently caused by his contact with the ground, when thrown over by the buggy. The lower lip is also slightly lacerated by the teeth. He complains of pain along the angles of the ribs below the right scapula; and on examination, fracture of the 5th and 6th right ribs, midway between their angles and their junction with the cartilages, is detected. There is no emphysema, and not the slightest bruise or excoriation on the front or sides of the chest, or of either shoulder; showing that the buggy could not have passed, as he supposes it to have done, across his thorax. On the upper and back part of the left shoulder, between the outer end of the clavicle and the root of the acromion, is a bruise about as large as the end of a buggy shaft, with some ruffling of the cuticle. There are several trifling bruises and excoriations on the back of the chest.

The patient complains chiefly of intense pain at the inner end of the left clavicle, and declares that the bone has been broken. No crepitus can be detected on passing the hand along the clavicle from without inwards: but on reaching the sternal origin of the sterno-mastoid, the clavicle can no longer be felt; and instead of its convex head, the finger encounters, on the upper angle of the sternum, a shallow cup-like cavity, which looks towards the left side, and slightly forwards and upwards. The right sterno-clavicular articulation is in a normal state, and presents a complete contrast to the left, showing a convex protuberance looking towards the mesial line, instead of a concavity looking away from it. There is no appreciable difference in the radial pulses, no numbness or coldness on the left hand, and no difficulty of respiration; indeed, considering that two of his ribs are broken, the patient is wonderfully free from distress. The distance from the acromion to the median line appears to be the same on both sides, but was not measured. There is great tenderness about the left sterno-clavicular joint, and the pain in it is so great as to engross the patient's attention; he barely alludes to that caused by the broken ribs. There is no especial tension of the left sterno-mastoid, and the end of the clavicle cannot be felt behind or through it.

The *reduction* of the dislocation was easily effected, without the aid of chloroform. The patient sitting up, I stood behind him, with my left foot on the bed, and fixed his thorax by placing my knee between his scapulæ; while with my left hand I grasped the dislocated clavicle, as near its sternal end as possible. Dr. Ewart, holding the patient's left wrist, extended the arm steadily backwards, outwards, and slightly downwards, until the dislocated bone was felt to move, when he lowered the arm sharply to the side, while I, at the same time, raised and pushed forward the clavicle, the sternal end of which slipped into its place with a sensible, and almost audible, "click." The reduction caused but little pain, and no difficulty was experienced from the resistance of any of the muscles. On letting go the arm, the clavicle showed no tendency to slip out of its proper place. A broad bandage was placed round the chest, and the left arm secured to the side by a second narrower one; and the patient was confined to the recumbent posture. The intense pain in the dislocated joint was at once relieved by the reduction; indeed, the patient cannot understand why his broken ribs and cut hand are not treated by us in the same off-hand and satisfactory manner.

The case has gone on well since, and the patient now (25th November) only complains of pain in the broken ribs. There is slight swelling, and a good deal of tenderness, over the dislocated joint, but no pain in it; and the clavicle has not shown any tendency to slip out of its proper place. He is discharged to-day, at his own request.

REMARKS.

Though not so rare as it was believed to be by Sir A. Cooper, this dislocation is still an uncommon one. As regards the absence of all difficulty of breathing or swallowing in the present case, this can easily be accounted for by the direction in which the force producing the dislocation acted. The man had evidently been struck by the buggy shaft on the left shoulder, and thrown over on his right side, thereby injuring his right hand, and breaking his right ribs. The force acted upon the clavicle by driving its outer end directly forwards, and also, probably, slightly upwards, and thereby forcing the sternal end of the bone backwards and slightly downwards, but not in the least inwards. I believe that the sternal end of the clavicle lay, in this case, directly behind and below the articulatory surface upon the sternum. Had the dislocation been caused by a force driving the shoulder inwards, instead of simply forwards, dyspnœa and dysphagia would doubtless have resulted.

LARGE FIBROUS TUMOUR OF ARM WITH DEPOSIT OF CANCER CELLS; AMPUTATION AT THE SHOULDER JOINT; RECOVERY.

BY KASSY KINCUR MITTER,
Sub-Assistant Surgeon.

INAYAT ULLAH, a Mahomedan boy, aged 12 years, a native of Jessore, was admitted in the Dr. Partridge's wards, into Medical